PAPERS AND ORIGINALS

Effects of legal termination on subsequent pregnancy

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Summary

Two hundred and eleven patients who had undergone vaginal termination and were pregnant again were investigated; 43.2% had become pregnant within one year of termination. The overall fetal loss in the 211 patients was 17.5% compared with 7.5% in a group matched for parity but consisting of patients who were pregnant after a spontaneous abortion. Altogether 4.3% of pregnancies after legal abortion ended as first trimester abortions, 8.5% as second trimester abortions, and 13.7% in premature delivery. Among 11 women whose cervixes had been lacerated at the time of legal termination the fetal loss in subsequent pregnancy was 45.5%, and only one pregnancy went beyond 36 weeks. Routine Shirodkar suture may be beneficial when the cervix is known to have been damaged at legal abortion. Several patients had asked that their general practitioner should not be told of their termination, and such patients may not admit their termination during a subsequent pregnancy, which could thus be jeopardised. No evidence was found to suggest that infants of patients with a history of legal termination are small for dates.

Introduction

Until 1975 the number of abortions carried out under the Abortion Act 1967 has steadily increased. In 1974 170 000 were performed in England, Scotland, and Wales.¹ Because of these large numbers it is essential that doctors, especially general practitioners and gynaecologists, should be fully aware of the risks associated with abortion. The operative and postoperative hazards have been emphasised²⁻⁴; Wright *et al*⁵ showed a high

incidence of second trimester abortion in pregnancies after vaginal termination. Jurokovski *et al*⁶ and Klinger⁷ showed, respectively, that perinatal mortality has doubled and the incidence of premature labour has increased in Hungary since the introduction of a liberal policy.

We noted an apparent increase in the number of women admitted to our labour suite in premature labour and that we were seeing many women in our antenatal clinic soon after a legal abortion. These impressions prompted us to carry out this survey. In this paper we present a study of women attending our antenatal clinic who had had a legal termination of their only previous pregnancy and report on the outcome of their present pregnancy.

Patients and methods

All patients booked for delivery in Southmead Hospital were asked if they had had a termination. Those patients who were in their second pregnancy, the first having been legally terminated, were specially followed. Patients who were in their second pregnancy after a spontaneous abortion of the first were also followed with special care as a control group. The outcomes of the second pregnancies in each of these two groups were compared.

We defined first trimester abortion as one occurring spontaneously up to the end of the 14th week, a second trimester abortion as one occurring spontaneously from the 15th to the 27th week, and premature labour as labour occurring before the 37th week of pregnancy.

Results

Despite good contraceptive advice after their termination 91 (43.2%) of the 211 women we studied had become pregnant within a year of their termination.

Among the 211 patients who had undergone a vaginal termination there were 208 single pregnancies and three sets of twins. In the spontaneous abortion group there were 146 single pregnancies and one set of twins.

There were significantly more first trimester abortions, second trimester abortions, and premature deliveries in the termination group than in the spontaneous abortion group (see table; $\chi^2 = 22.52$; $P > 0.01$). Only one child born in the mid-trimester to a mother in the termination group survived. It was born at 27 weeks' gestation and weighed 1000 g. Among the deliveries to 155 women who had had legal

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abortions and who delivered after 37 weeks there were two neonatal deaths due to fetal abnormality. Among the 136 deliveries after 37 weeks in the spontaneous abortion group there were two perinatal losses, again both due to fetal abnormalities. There were nine perinatal deaths among the 29 premature deliveries in the termination group. None of these was due to fetal abnormality. Several other infants are being followed by paediatricians, who expect a high morbidity or delayed mortality in this group. Indeed, at least two infants have already died in early infancy. In contrast, there were three abnormal infants among the prematurely delivered infants in the spontaneous abortion group.

Outcome of subsequent pregnancies after termination or miscarriage

	1st trimester abortion		2nd trimester abortion		Premature deliveries		Term deliveries	
	No	%	No	%	No	%	No	%
Termination group	9	4.3	18	8.5	29	13.7	155	73.5
Spontaneous abortion group	2	1.4	2	1.4	7*	5.2	136	92.5

*Includes one patient induced at 28 weeks because of fetal abnormalities.

One hundred and nine (51.7%) mothers in the termination group delivered between 37 and 40 weeks and 46 mothers (21.8%) delivered after 40 weeks. In the spontaneous abortion group 59 patients (40.1%) delivered between 37 weeks and term and 77 (52.4%) delivered after term. The termination group tended to have shorter pregnancies than the spontaneous abortion group. These differences were statistically significant. ($\chi^2 = 21.55$; $P > 0.001$).

Small-for-dates infants—There were 184 infants born after 28 weeks' gestation in the termination group. The weights of 16 of these infants (8.7%) were below the 10% percentile.

Cervical laceration—Whenever possible we reviewed the operation notes of the termination. The cervix was noted to have been lacerated during dilatation in 11 cases (5.2%). In these 11 cases only one of the subsequent pregnancies continued beyond the 36th week and only five infants survived. There were four second trimester abortions, one 30th-week stillbirth, and one 33rd-week neonatal death.

Discussion

We have found that among women who became pregnant after legal termination 43.2% did so within a year of the termination, a figure in keeping with the results of Clow and Crompton,⁸ who found 58% of women pregnant within one year of hysterotomy. Either our contraceptive advice is not heeded or these women consciously or subconsciously desire pregnancy. The social grounds on which the request for termination had been mainly based often remained unchanged at the beginning of the subsequent pregnancy.

The overall fetal loss in the termination group was 37 (17.5%). This figure was made up of nine first trimester abortions, 17 second trimester abortions, nine premature deliveries, and two neonatal deaths. In the spontaneous abortion group the fetal loss was 11 (7.5%). The results for those who had undergone

legal termination are conservative figures, and the true picture among these women is almost certainly far worse. We included only patients who attended our antenatal clinics and not those who were admitted as emergencies to gynaecological wards.

We found significantly more first and second trimester abortions and premature deliveries in our termination group than in our other group. The mid-trimester abortion rate of 8.5% and premature delivery rate of 13.7% agree closely with the findings of Wright *et al.*⁵ and Klinger.⁷ Our findings strongly suggest that cervical incompetence is responsible for this high fetal loss, and the poor results when the cervix was known to have been damaged lend weight to this suggestion. We believe there is a definite place for routine Shirodkar suture in patients known to have sustained cervical damage. The importance of accurate operation notes in vaginal termination is obvious and it must be impressed on the patient that she must not keep her future obstetrician ignorant of previous termination. This becomes even more important if the cervix was lacerated or the uterus perforated. It is disquieting that some patients referred to us from pregnancy advisory centres asked that their general practitioners should not be told of their referral. It seems reasonable to assume that these patients will not admit their termination during a future pregnancy, a view that we share with Wright *et al.*⁵ We have seen cases in which this failure to provide information has ended in near disaster, not only for the fetus but for the mother as well.

Unlike Clow and Crompton⁸ we found no increase in growth retardation after legal abortion, but, clearly, after a vaginal termination there is considerable risk to a subsequent pregnancy and we feel that these dangers should be realised by general practitioners and non-gynaecological specialists.

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